STATE OF RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES
PROVIDER AGREEMENT FORM

_____ (Provider) with the understanding that participation in the Rhode Island Department of Human Services Medical Assistance Program hereafter, "DHS" or "RIMAP" is voluntary, agrees to the following:

1. To follow all laws, rules, regulations, certification standards, policies and amendments including but not limited to the False Claims Act and HIPAA, that govern the Rhode Island Medical Assistance Program as specified by the Federal Government and the State of Rhode Island. Suspected violations must be reported by the Provider to DHS, its fiscal agent, or the Medicaid Fraud Control Unit of the Rhode Island Attorney General's Office.

2. To be licensed, certified, or registered as required by State and/or Federal law. The Provider will notify RIMAP within seven (7) days of any adverse action initiated against the license, certification, or registration of the provider or any of its officers, agents or employees.

3. Certification regarding debarment, suspension and other responsibility matters.

   The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:

   a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transaction by any Federal or State department or agency:

   b. Have not been convicted of or had a civil judgment rendered against them for commission of fraud; violation of Federal or State antitrust statues or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; and

   c. Are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (1) (b) of this certification.

4. To provide medically necessary services, goods, or products within the amount, duration, and scope of the RIMAP, to beneficiaries consistent with the provider's qualifications and adhere to professional standards governing medical care and services.

5. To maintain, for a minimum of ten (10) calendar years after the year of service, information and records necessary to determine the nature and extent of services rendered under the RIMAP and furnish them in the State of Rhode Island upon request by the Secretary of Health and Human Services (HHS), the RIMAP, and to the Department of Attorney General Medicaid Fraud Control Unit. Further, the provider specifically agrees to notify the Secretary of HHS and the RIMAP, within thirty-five (35) days of any agreement or transaction relating to the provider's ownership interest in any subcontractor with whom the provider has had business transactions exceeding the lesser of $25,000 or 5% of the provider's total operating costs during the immediately preceding twelve (12) month period. In addition, the provider agrees to notify DHS of any significant business transactions including, but not limited to, any change of ownership or control interest of

the provider, bankruptcy, mergers, and transaction which exceeds the lesser of $25,000 or 5% of the provider's total operating costs within any twelve (12) month period, between the provider and any wholly owned supplier or between the provider and any subcontractor within thirty-five (35) days of said transaction.

6. To accept the rates of fees and reimbursement of the RIMAP as the sole and complete payment in full for services, goods or products delivered to beneficiaries, except for payment made from the beneficiary's applied income, authorized co-payments, cost sharing, or spend-down liability.

7. To offer services in accordance with Title VI of the 1964 Civil Rights Act and Section 504 of the Rehabilitation Act of 1973, as amended, as well as all State and Federal laws that prohibit discrimination on the basis of race, sex, age, color, religion, national origin and handicap.

8. To fully exhaust the beneficiary's other medical insurance or other third party sources for payment for medical care prior to submitting Medical Assistance claims for reimbursement; to report third party payment and acknowledge the RI Medical Assistance Program as payer of the last resort; to assist the RIMAP in identifying other possible sources of third party liability for those beneficiaries who may have legal recourse to pay all or part of the medical costs.

9. To notify the Department of Human Services directly or through its fiscal agent of material and/or substantial changes in information contained on the enrollment application given to the Department by the provider. This notification shall be made in writing within thirty-five (35) days of the event triggering the reporting obligation.

10. To bill the RI Medical Assistance Program in accordance with State and Federal regulations and laws, but in no event more than the provider's usual, customary, and reasonable rate charged to the general public for all services, goods, and products provided to Medical Assistance beneficiaries.

11. On each claim form or transmittal document for the claims submitted via electronic means, to certify by signature of the provider, or if the provider is organized as a corporation, partnership, limited partnership, limited liability corporation, or other business entity, an owner, partner, director, or officer of that entity, that the goods or services listed were medically necessary, authorized (if the goods or services claimed required preauthorization under existing statutes or regulations), and actually rendered to the RIMAP beneficiary. The Provider shall be responsible for the accuracy of claims submitted, whether in paper or electronic form. Provider acknowledges that neither the Department nor its fiscal agent bears responsibility for the review and correction of inaccuracies in any claim form or transmittal submitted by the Provider.

12. To submit claims and documentation in a form acceptable to DHS and its fiscal agent; to receive payment in the form of electronic funds transfer, such payments maybe held at a transfer in charge of ownership for reconciliation in recoupment.

13. To acknowledge that administrative, civil, or criminal action may be initiated if the Provider is found in violation of RI Medical Assistance Program statutes, rules or regulations.

14. In the event that the Department, its fiscal agent, or the Attorney General's Medicaid Fraud Control Unit determines that there is probable cause to believe that an overpayment has been made to the Provider by inaccuracy or fraud in the Provider's submission of claims as set forth in Paragraph 11, the Provider agrees that an amount equal to the overpayment may be withheld by the Department pending investigation and/or settlement of the disputed claim. Suspected

violations must be reported by the Provider to DHS, its fiscal agent, or the Medicaid Fraud Control Unit of the Rhode Island Attorney General's Office.

15. To acknowledge and accept as incorporated by reference the definitions of terms included in – Glossary Definitions. (See Addendum I)

16. To agree that any amendments or revisions to this Provider Agreement must be made in writing and signed by both parties.

17. That, I as the signatory, is binding all of the employees, agents and representatives providing services under this provider number to all of the terms of this agreement.

18. Medicaid providers who employ individuals applying for benefits under any chapter of Title 40 shall comply in a timely manner (within 14 days) with requests made by the Department for any documents describing employer sponsored health insurance coverage or benefits the provider offers that are necessary to determine eligibility for RIte Share, the State's premium assistance program pursuant to section 40-8.4-12. Such documents requested by the Department may include, but are not limited to, Certificates of Coverage or a Summary of Benefits and employee obligations and/or financial contribution. Upon receiving notification that the Department has determined that the employee is eligible for premium assistance under section 40-8.4-12, the provider shall accept the enrollment of the employee and his or her family in the employer based health insurance plan without regard to any seasonal enrollment restrictions, including open enrollment restrictions, and/or the impact on the employee's wages. If required by the Department, enrollment in an employer based health insurance plan is a condition of Medical Assistance eligibility regardless of any existing pay-in-lieu of benefits arrangement. Providers who do not comply with the provisions set forth in this section shall be subject to suspension as a participating Medicaid provider.

19. This is to certify that the information provided in support of the Provider Application is true and accurate and I completely understand that any falsification or concealment of a material fact may be prosecuted under Federal and State Laws. Willful misstatement of any material fact in the application may result in criminal prosecution. I acknowledge that this is being signed under the pains and penalties of perjury and understand that the department is relying on the accuracy of the information I have presented. I understand and accept that my signature herein denotes acceptance of the terms of this agreement, which are binding upon all of my employees, agents and representatives.

Signature of Provider, Senior Partner, Chief Corporate Officer, or Authorized Agent Title Date

Full Name (printed)

Provider Number (printed)